CENTERS FOR MEDICARE AND MEDICAID SERVICES

2008 Physician Quality Reporting Initiative – Participation by the American Optometric Association (AOA)

Conference Leader: Daniel Green, M.D.
Moderator: Natalie Highsmith
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2:00 pm ET

Operator: Good afternoon. My name is (Mindy). And I will be your conference facilitator today.

At this time I would like to welcome everyone to the Centers for Medicare and Medicaid Services Special Open Door Forum on 2008 Physician Quality Reporting Initiative with participation by the American Optometric Association.

All lines have been placed on mute to prevent any background noise.

After the speakers' remarks there will be a question and answer session. If you would like to ask a question during this time simply press star then the number 1 on your telephone keypad. If you would like to withdraw your question press the pound key.

Thank you. Ms. Natalie Highsmith you may begin your conference.

Natalie Highsmith: Thank you (Mindy) and good day to everyone and thank you all for joining us for this Special Open Door Forum on the 2008 PQRI Initiative with participation by the American Optometric Association.

The purpose of this Special Open Door is for providers to gain an understanding of PQRI and encourage participation by providing simple steps that physicians can use to collect and report data to CMS.

Successful reporting of this data will make the professional eligible for an incentive payment from CMS.

There will be an audio recording of this call posted on the Special Open Door Forum web page beginning October 3rd and also the presentation materials for today are on the PQRI web site, www.cms.hhs.gov/pqri under the CMS Sponsored Call link and under if you scroll down and underneath the related links outside CMS you will see the link for the PowerPoint presentation for today.

I'll go ahead and turn the call over to Dr. Dan Green who is the Medical Officer and in our Quality and Measurement in Health Assessment Group in our Office of Clinical Standards and Quality.

Dr. Green.

Daniel Green: Thanks Natalie. I'd like to also extend a welcome to everyone today and thank you for your participation in today's call and for your interest in the Physician Quality Reporting Initiative.

As you all probably know the eye care measures in 2007 were some of the most widely reported measures and we are certain that that's due in large part to the optometrists and the ophthalmologists out in the community and we do thank you for your interest and your participation.

Today we are fortunate to have three experts who will be speaking. The first is Dr. Peter Kehoe. He was first elected to the American Optometric Association Board of Trustees in June, 1999 and Dr. Kehoe was reelected in 2002.

He ascended to the presidency at the 111th Annual AOA Conference and the 38 Annual AOSA Conference, Optometry's Meeting in June of 2008.

Dr. Kehoe's responsibilities as President include serving as a member of the AOA Executive and Agenda Committee. He's the Board liaison to the American Academy of Optometry and National Optometric Association.

Dr. Kehoe also serves as a liaison to various regional optometric councils and organizations.

He is past President of the Illinois Optometric Association and the West Central Illinois Optometric Society and continues to serve as the Illinois Optometric Association's Legislative Committee and was named Optometrist of the Year in 2001.

Dr. Kehoe is a graduate of the Illinois College of Optometry and served on its Alumni Council, Board of Directors. He is the principal in a multi-location group practice in Galesburg, Illinois, a fellow of the American Academy of, excuse me, Optometry and is past President of the Galesburg Lions Club.

We're also pleased to have Dr. Rebecca Wartman. She is an AOA Correct Coder Trends Committee and Eye Care Benefits Center member.

She is a graduate of the University of Missouri, St. Louis School of Optometry. She's in private practice in Asheville, North Carolina serving more than 50 nursing homes.

She's the 2008 North Carolina State Optometric Society Optometrist of the Year.

Boy everybody speaking today is an Optometrist of the Year, that's great. Told you we were fortunate.

Dr. Wartman has served on the AOA Eye Care Benefits Center since 2003 and it's Correct Coding Subcommittee. She's also held numerous positions at the North Carolina State Optometric Society including President in 2001 and 2002.

She's published numerous articles and papers and recently has written specifically about reporting quality measures and, excuse me, and has contributed to the educational resources available on the AOA web site.

She has published articles on the PQRI and American Optometric Association News as well an article on reporting quality measures with Level II CPT codes and the Journal of American Optometric Association.

We also are fortunate to have Dr. Harvey Richman. He's also a member of the AOA Correct Coding Trends Committee and the Eye Care Benefits Center.

Dr. Richman is a practicing optometrist in New Jersey. And he graduated from New England College of Optometry in 1991 and was named Optometrist of the Year in 2007 by the New Jersey Society of Optometric Physicians.

Dr. Richman serves as the Correct Coding Subcommittee; I'm sorry, serves on the Correct Coding Subcommittee of the AOA Eye Care Benefits Center since 2006 and chairs the New Jersey Low Vision Committee.

He will be President of the New Jersey Society of Optometric Physicians in October, 2008 and chairs several of the society's committees.

He's made numerous presentations within the last year on Physician Quality Reporting Initiative. He also lectures frequently on coding, low vision management, and eye examinations for children. Excuse me.

In addition he's published articles for the general public and for the optometry offices, audiences, excuse me, including a chapter in 2007 for the AOA Paraoptometric Association Review Book.

Finally we also have Rodney Peele from the AOA. He is the Assistant Director for Regulatory Policy and Outreach and he will be also available to answer questions and questions that are not answered on today's call may also be directed to Mr. Peele at the AOA.

So after that introduction I'd like to turn the call over to Dr. Peter Kehoe for some general opening remarks.

Thank you.

Peter Kehoe: Well thank you Dr. Green. We appreciate very much your participation on this call and your very much expertise and insight into the program.

We also want to thank CMS for co-hosting this call and we hope that this event will encourage more optometrists to participate in the Physician Quality Reporting Initiative.

The AOA actively seeks to educate our members about PQRI reporting. In addition to this call we have resources available on the AOA web site for our members and we have published articles regularly in the Optometry Press about quality reporting.

As you've already been made aware we're very fortunate to have Dr. Rebecca Wartman on the call. She's going to present on the PQRI reporting for optometrists in 2008 and 2009 and she's a wonderful resource.

And I'm also pleased that Dr. Richman is on the call to discuss the PQRI Feedback Report from 2007. He will speak from his experience going through the process personally to obtain feedback.

The experts on the call from CMS are the true leaders of the PQRI Program. They have spent many months trying to make this an easy worthwhile and successful quality improvement program while following the intent of Congress.

PQRI is a step in the transition to a value-based purchasing system.

And I want thank CMS on behalf of the American Optometric Association for being accessible and responsive to us regarding the PQRI Program.

We're very fortunate that we've developed this very close working relationship and I want to thank CMS personally and on behalf of all of our members.

And with that to get moving on with this I want to start and introduce Dr. Rebecca Wartman. It's all yours.

Rebecca Wartman: Thank you Dr. Kehoe, Dr. Green and Natalie (Smith) (sic). I really appreciate you hosting this.

Let's go ahead and get into the meat of this presentation. If you have the PowerPoint presentation in front of you I will refer to slide numbers so you can keep up. If not you can download the slides at a later date.

Slide 2 and Slide 3 are disclaimers. You can read those at your leisure. Just keep in mind that anything that I say for 2009 is subject to change as late as December 31, 2008 so nothing is really set in stone yet. The final rule will be published on November 15, 2008 but the specifics of the application may change as late as December 31st.

Slide 4, the Physician Quality Reporting Initiative or PQRI is actually pay for reporting. It is voluntary for 2007 to 2009.

Originally the legislation that brought PQRI to the forefront was the Tax Relief and Healthcare Act of 2006 that authorized the financial incentive for professionals by reporting quality data.

It was updated with the Medicare, Medicaid and SCHIP Extension Act of 2007 that continued the authorization for PQRI for 2008 and 2009, and finally updated by the Medicare Improvement for Patients and Providers Act of 2008 that expanded the bonus payments for 2009 and 2010.

Slide 5, the quality in PQRI. PQRI focuses on the quality of care. The measures that are used are evidence-based and they were developed with professional input.

The reporting of these measures is financially rewarded with a bonus payment.

And it is hoped that the measurements enable physicians to provide improved care.

And it is the first step toward pay for performance if that's still a term that's in use.

The PQRI reporting uses CPT Category II codes and these - there are several CPT Category II codes that are published in the CPT Book. But in the event there is not a published CPT II code then G-Codes may be used to report the quality data.

And some of the CPT II codes may be implemented before they're actually published in the paperback book but those will be posted and available online.

And again if there's not a published CPT II code for PQRI then generally we are going to use G-Codes that are specified by CMS.

CPT II codes are now referred to as Quality Data Codes or QDC Codes.

Slide 7, PQRI reporting can be made with paper-based CMS 1500 claims or electronic filing with 837P claims.

PQRI reporting does need to occur on the same claim form as your regular codes are filed for a claim for a patient encounter.

There's no registration to participate in PQRI. You can just participate. And it is voluntary at least through 2009 at this point.

For satisfactory reporting you have to report at least three measures 80% of the time to be eligible for the bonus payment. With eye care codes we're lucky to have at least four codes plus some other additional codes that we can report so three measures 80% of the time is a fairly obtainable goal.

The AOA recommends that you report and submit CPT II codes or Quality Data Codes or the G-Codes that are applicable on all reportable cases to ensure that the 80% goal will be met so the bonus will be paid to you.

Slide 9, PQRI codes, II codes, Quality Data Codes may be put on the CMS 1500 form or on your claim form at a zero dollar charge or a nominal fee of a penny or so if your system requires that you actually put a value on each code that you put in.

But again they do have to be filed on the regular claim. You cannot re-file a claim just to add the Quality Data Codes. Those will not be counted in the analysis.

PQRI line items that are submitted will be denied on your Explanation of Benefits and they will be noted that they were denied.

But that does not mean that the data is not sent to the National Claims History File for analysis. It is indeed sent even though it will be denied.

Slide 10, the PQRI bonus payment for 2008 will be 1.5% as it was in 2007 with checks in the mail in July of 2009.

The 2009 PQRI bonus will be set at 2% so it will go up in 2009.

The bonuses are based on all the Medicare allowable charges that have been submitted by a provider including any diagnostic services filed with the TC Modifier.

The bonus payments are made to the holder of the Tax ID Number but feedback reports are broken down by National Provide ID Number or NPI Number.

Slide 11, PQRI eye care measures. Well all PQRI measures are divided into a numerator and a denominator. This is definitely true for eye care measures.

The numerator is the appropriate Quality Data Code or CPT II code or G-Code that's assigned to the PQRI measure and the denominator is the CPT I code procedure or an E&M code plus the appropriate diagnosis that is applicable to the measure and any other factors that might be applied to the measure such as age or frequency of the reporting.

For 2008 the PQRI measures included 119 different measures. There were four specific eye care quality measures and two health IT structural measures included.

There were five other preventative measures that might be used by optometrists and there may have been a few more.

But we did not detail those in any of the documents that we produced for PQRI because they're fairly far outside the eye care realm.

For 2008 the claims-based reporting, the reporting period was January 1, 2008 to December 31, 2008.

Slide 13, some strategies for participating in the quality data reporting. First you identify the diagnosis code or ICD-9 code and the appropriate CPT 1 code for your patient.

And then if appropriate you choose a CPT II code or Quality Data Code for that measure and you apply any exclusion modifiers that might be required. I'll discuss the exclusion modifiers in just a moment.

Some of the measures did have G-Codes that you needed to use because there was no CPT II code developed at the time for that particular portion of the measure.

And when you use a G-Code there is no modifier that is required. Each code describes a different situation.

So the modifiers would only be put on the QDC or CPT II codes.

Slide 14, the modifiers that are used, there are four exclusion modifiers. They're only used to indicate exclusions. A 1P modifier would be an exclusion due to medical reasons.

For example if your patient had a total cataract and you could not do a fungus exam but yet you knew that they had glaucoma that might be a reason to use a 1P exclusion because you weren't able to view the optic nerve.

A 2P modifier is an exclusion due to a patient reason. In a measure that requires a dilation, if the patient refused the dilation you might use the 2P exclusion modifier to indicate that you could not dilate for a patient reason.

A 3P modifier is an exclusion due to system reasons. This is generally used for eye care measures when the physician reporting the measure is not the one primarily responsible for that disease.

If you were co-managing a macular degeneration patient with a retinal specialist and their primarily responsible for the macular degeneration care, you would use a 3P modifier.

And then an 8P modifier will be used if you just - if you didn't do the measure for any other reason but you knew it should be reported.

Now on Slide 15, in 2007 there were four eye care measures that were deleted in 2008 and just briefly they were measure 13 for the AREDS prescribed or recommended for macular degeneration.

Measure 15 was the visual function status assessment for cataracts.

Measure 16 was the pre-surgical measurements for cataracts.

And measure 17 was pre-surgical dilated fungus evaluation for cataract surgery.

All four of those measures were deleted for 2008.

On Slide 16, we're going to detail the measure, the eye care measures for 2008 and I'm going to be fairly brief.

Measure 12 was the CPT II code is 2027F. This measure is a primary open angle glaucoma optic nerve evaluation. The numerator again is 2027F. The

denominator is 18 years and older, any of those five glaucoma diagnosis codes for open angle glaucoma.

The CPT I codes apply. The denominator are the E&M Codes and the 9200 Ophthalmic Codes as well as the Nursing Home and Rest Home Evaluation Codes which are new for 2008.

And you have to report this measure at least once in a 12 month period.

The exclusion codes, the modifiers to put on this code were 1P, not performed for medical reasons; 3P not performed for system reasons; and 8P not performed reason not specified.

Again new for 2008 for this measure was the addition of the 3P modifier and the addition of the Nursing Home and Rest Home Evaluation Code.

Measure 14 is the next eye care measure. It is age-related macular degeneration dilated macular exam.

And the numerator is 2019F. The denominator is 50 years and older. One of the three macular degeneration diagnosis codes listed and the procedure codes would be the E&M codes, the 9200 Ophthalmic Codes and the Nursing Home and Rest Home Evaluation Code.

The documentation that is required is presence or absence of macular sickening and presence and absence of hemorrhages in the macula.

And you have to report this code at least once in a 12 month period.

The modifiers for measure 14, 2019F are 1P medical reasons for not performing; 2P patient reasons for not performing; 3P system reasons; and 8P other reasons.

Again the changes for 2008 were the addition of the 3P modifier and the Nursing Home and Rest Home Evaluation Code.

The next measure we're going to talk about is measure 18, the diabetic retinopathy. It's the documentation of the presence or absence of macular edema and the level of severity of retinopathy.

The numerator is 2021F. That's the CPT II code for this measure. The denominator is 18 years and older. One of the six diabetic retinopathy codes are the diagnosis codes allowed, and the 99 Evaluation and Management Codes, the 9200 Ophthalmic Codes, and the Nursing Home and Rest Home Evaluation Codes.

It's important to note here that you have to document for proper coding diabetic retinopathy before you can code macular edema.

So the 362.07 diagnosis code is not one of the listed denominator codes for this measure.

And you have to report this measure at least once within the 12 month period.

The exclusion modifiers again are 1P for medical reasons; 2P for patient reasons; 3P for system reasons; and 8P for other reasons not specified.

And the changes for 2008 for this measure were 3P modifier addition and the Rest Home and Nursing Home Evaluation Codes.

Now I'm on Slide 22. Forgive me for not keeping up with the slide numbers.

Measure 19 is a bit more complicated. This measure is diabetic retinopathy communication with the physician managing ongoing diabetes care.

And again this is for patients who have documented retinopathy. That doesn't mean that you wouldn't report measure 18, the 2021F. This is separate from that.

Last year you had to report these two measures together, 18 and 19. This year they're separate.

Measure 19 is - the numerator is 5010F with or without a modifier and a G-Code of G8397 or just the G-Code of 8398.

And I'll go into a bit of detail on this because this one can be a bit more confusing.

The denominator is 18 years and older with diabetic retinopathy. Again the diagnoses or the diabetic retinopathy diagnoses. The procedure codes are the Evaluation and Management Codes, the 9200 Ophthalmic Codes and the Nursing Home and Rest Home Evaluation Codes.

And you have to report this measure at least once in a 12 month period and the communication with the diabetes managing physician has to be documented.

Slide 23, the modifiers for the 5010F portion of this measure are 2P patient reasons for not communicating, maybe the patient told you couldn't send a

letter; 3P documentation for system reasons for exclusion; and 8P documentation of other reasons for not communicating.

Okay, the changes for 2008 were the addition of the 1P modifier - the 1P modifier was eliminated. And the 3P modifier was added.

And you also have to code either the G8397 with the 5010F or the G839801.

Again last year it did require that the coding of measure 18 and 19 together.

And then this year they also added the Nursing Home and Rest Home Evaluation Code.

Slide 24, G8397 is dilated macular or fungus examination performed including the documentation of the presence or absence of macular edema and the level of severity of retinopathy. Again it's basically saying that you actually did measure 18.

Or if you did not dilate then a dilated exam was not performed, then you would file this measure simply with a G8398.

Just to further clarify this measure on Slide 25 it goes through the different scenarios of the use of the 5010F with and without modifier and the G8397.

So you would file those two together. If you did the dilation then you need to file 5010F with or without a modifier and 8397 again together.

However if you don't dilate the only thing you need to report for this measure is the 8398, G839801.

So that's a bit of a complication on that measure. Once you start actually doing it its pretty simple but when you first think about it it's very confusing.

Now Slide 27, we're going to talk about the diabetes measure.

And this is a new measure for 2008 for eye care providers.

Measure 117 has four different CPT II codes that could be used for this measure because the measure is a dilated eye exam in a diabetic patient.

And the addition of the 9200 codes and the denominator is the biggest change from 2007 which is why at this point the AOA felt like we could add it as a measure. The E&M, the regular E&M 99 codes had always been reported as a denominator but now the 9200s were added.

This measure again does have four different CPT II codes. On Slide 28 I detailed those.

The most common to be used by an eye care professional would be 2022F. That describes the dilated retinal eye exam with interpretation by an ophthalmologist or an optometrist documented and reviewed.

2024F would be the seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed.

2026F is eye imaging validated to match diagnosis from seven standard field stereoscopic photos, results documented and reviewed. This would basically be ophthalmic seven field images taken and sent to a remote reading center.

And 3072F would be low risk for retinopathy meaning the patient had no retinopathy the year before thus a dilated exam was not necessary this year.

On Slide 29, measure 117, again the numerator is one of those four. The most common would be 2022F, a dilated eye exam in a diabetic patient. The denominator would be ages 18 to 75.

So if your patient is 76 you wouldn't report this measure.

The diagnoses codes are much more expansive than the other diabetic measurements. They include regular diabetes and in a lot of variations on those as well as diabetic retinopathy and macular edema so there's a long list of diagnosis codes or ICD-9 codes that go with this.

The procedure codes are 9200 codes, 9900 codes as well as some consultation codes so you can look those up. And they're on the slides.

Modifier 8P, no dilation performed, reason not specified, is the only modifier allowed for this measure and at least once in a 12 month period for those patients 18 to 75 years old.

Now Slide 30, there were two health IT measures for 2008 that optometrists could use.

Measure 124 describes the adoption and use of health information technology electronic health records.

Now to use this measure you must have and routinely use a CCHIT certified or a qualified electronic medical record system as defined in the measure.

And the measure gets into great detail about exactly what qualifies an EMR so you really need to view the AOA web site for any more details if you're interested or the CMS web site.

The numerator is three different ones. G8447, a patient encounter documented using a CCHIT certified or a qualified EMR; or G8448, a patient encounter documented using a non-CCHIT certified EMR but a system that meets qualifications listed in the measure.

And G8449, the patient encounter was not documented using an EMR because of system reasons such as the system being inoperable at the time of the visit. However to use this code it implies that an electronic medical record is in place and generally available for use.

So you would not use this measure if you did not have a certified or a qualified electronic medical record for general use.

Now measure 124 continuing on that, then you have to again have a certified or qualified EMR. The denominator is 18 years and older. The procedure codes and diagnosis codes are extensive. There's an extensive listing of those.

And it's reported on every encounter as qualified. It's not once every 12 months. It's every encounter it's qualified.

And there are no modifiers listed for this because they're G-Codes.

Now on Slide 32, a certified or qualified EMR is a CCHIT certified EMR. Just briefly a non-CCHIT or certified EMR is a system that is capable of generating a medication list, a problem list and capable of entering laboratory

results as discreet searchable elements. Those three conditions must be met to be a qualified EMR.

And currently there are no commercially available certified eye care specific EMRs available.

Now on Slide 33 the next health IT measure is measure 125. This is the adoption and use of e-prescribing.

And this measure will change in 2009. It will not be a PQRI measure. It will be a standalone bonus measure. It will be recorded in 2009 again as separate with an additional bonus paid for that use.

And if my reading is correct and Dr. Green can certainly help us with this later, as of 2010 or ’11 you will actually start being penalized for not using e-prescribing so this is becoming a very, very important measure.

The AOA does encourage all RDs to explore the use of e-prescribing technology and in fact there’s a special seminar coming up by CMS that AOA as well as many other groups are helping to sponsor.

On Slide 33, I’m not going to get into the details of those measures - of that measure but there were three different G-Codes that you could use for that measure.

On Slide 34, for 2008 there were some preventative measures that optometrists and ophthalmologists could use.

Measure 128 was the universal weight screen and follow-up.

Measure 114 was the inquiry regarding tobacco use.

Measure 115 was advising smokers to quit.

Measure 129 was the universal influenza vaccine screening and counseling.

For the following specifics and examples you can go to the AOA web site for PQRI that's listed in this presentation.

And it will give you all the details and all the specifics that you need. We did detail these in the literature that's come out from before.

On Slide 35, for 2008 there were some other preventative measures that weren't commonly reported by optometrists but we did discover these are showing up on the PQRI 2007 Feedback Report because the regular E&M codes were in the denominator with no specific diagnosis codes.

Those other five screen measures were screening for falls risk, screening for osteoporosis, medication, advanced care plan, and urinary incontinence. As you can see by those titles not many eye care professionals would be dealing in those areas as a general rule.

Slide 36, the new proposed measures for 2009. These are currently eye care test measures.

And if they're finalized in the November rule, these could become applicable to eye care providers. However we don't know for sure that that's going to happen.

The three test measures just briefly on Slide 36 were the test measure 139 which uses the CPT II code of 0014F, cataracts. A comprehensive preoperative assessment for cataract surgery with intraocular lens implants. It's my understanding that these are generally thought to be reported only by the physician performing the surgery.

T140, this test measure uses CPT II-4. CPT II code or Quality Data Code of 4177F, age-related macular degeneration, counseling on antioxidant supplements. This is a bit of a change from the 2007 AREDS formula guidelines so you'll need to keep alert for that when these measures do come out.

And test measure 141 using the Quality Data Code or CPT II code of 3284, primary open angle glaucoma, the reduction of intraocular pressure by 15% or the documentation of a plan of care, so those three are expected to be three additional eye care measures for use in 2009.

On Slide 37, some other new measures proposed for 2009, we'll talk about in just a minute. The specifics for the test measures are outlined at the AOA web site listed on Slide 37.

Again to emphasize these are subject to change before 2009 if they're adopted in the final rule.

And we know the final rule until November 15th of 2008.

And if anybody out there participated in 2007, you'll know that some of these measures look a little bit similar to the measures that we had in 2007 that were dropped in 2008.

On Slide 38, for 2009 the measures are made by rule making. They're proposed by the Medicare Physician Fee Schedule Proposed Rule in June 30th of 2008 and they will be finalized by November 15th although the specifics may not really be in place until December 31, 2008.

The proposed measures currently include 113 of the current 2008 measures, the 17 new measures that have been endorsed by the National Quality Forum, 20 new measures that have been adopted by AQA, and 25 new measures that are proposed for 2009 that are still contingent on either the NQF endorsement or the AQA adoption.

Slide 39, for 2008-2009 there's some new alternatives for reporting however just to make you aware of these they're not likely to be used currently by optometrists.

The reporting of measure groups, require a reporting of a set of related measures for a specific disease entity and we'll talk about those in specific in just a minute.

And the goal is to assure that the patients receive appropriate care for a clinical situation.

As well PQRI data can be accepted by clinical registries and electronic health record system. But again the AOA does not anticipate this will be - many optometrists would be impacted by these alternative routes of reporting.

In 2009 CMS is increasing the number of conditions covered by measure groups to nine.

In 2008 the groups included diabetes, chronic kidney disease and preventive care.

And in 2009 it's expected they will add coronary artery disease, HIV-AIDS, coronary artery bypass surgery, rheumatoid arthritis, care during surgery and back pain as possible measure groups.

Now just to give you an idea of what a measure group might look like I'm going to review the diabetes measure group.

Measure 1 is the hemoglobin A1c poor control in diabetes; measure 2 low-density lipoprotein control in diabetes; measure 3 high blood pressure control in diabetes; measure 117 a dialated eye exam in diabetic patients. That's where we come in.

And then measure 119 is a urinary screen for microalbumin or medical attention to nephrothopy in diabetes.

So that's just an example of what a measure group might look like. This measure group includes five different measures on a diabetic patient that needs to be met to report the measure group.

The preventive measure group has several things in it that will look a bit familiar.

The screen for osteoporosis, this is on Slide 42. The assessment of urinary incontinence for older women, influenza vaccine, pneumonia vaccine, mammography, colon rectal screening, tobacco use inquiry advising smokers to quit and a universal weight screen. So that was the preventive measure group.

That if so desired and you could meet the coding guidelines you could file as an eye care provider however again those aren't very common.

Just in summary we have four eye care measures for 2008. We anticipate seven eye care specific measures for 2009 as well as some ancillary measures so stay tuned for the details.

And I'm going to turn it over to Dr. Richman to talk about the report.

Harvey Richman: Thanks Dr. Wartman. Again for those people that are used to looking at the slides I'm going to try and work along with them but I may go a little bit tangential as we go along anyway.

Starting off basically we're going to do a little bit of review like Dr. Wartman did, first is that PQRI analysis is done by first looking at each individual (NPI) under the Tax ID Number of the organization.

When you get your report which we're going to talk about later, it will break it down to each of the NPIs on the group.

The individual in the group must reach the 80% reporting measurement, 80% reporting threshold that Dr. Wartman had referred to and the Board consensus is based on the estimate of all the (out) charges for eligible professionals during that period.

For the period that we're talking about it's going to be specifically July 1st through December 31, 2007. The 2008 stuff is not out yet. I'm assuming that the mechanism that we're going to talk about for reviewing the information

will maintain the same. Hopefully there will be no new forms, applications and processes that we're going to have to produce.

The incentive - next Slide 45, incentive payments for the satisfactory reporting were issued in mid-July this year. We received, basically what ended up happening, we received a deposit, direct deposit into our account and no documentation from it at which point we started contacting our local Medicare Advisory Carrier and asked them what was this, why was this.

And that was when we started to find out these were the PQRI checks that started to come out. We weren't sure exactly why because the documentation had not come out at the same time.

We actually got one that was individual but apparently it may be rolled into a check with other Medicare claims on that day.

The payment was made to the Tax ID Number that is on file there. And then the visibility of it can then be done via NPI later on.

Next slide, payments to our group specifically, and again I'm going to talk about my group as we go along here, was done through a single carrier. There are many states that have multiple carriers that may potentially be doing - you may be providing services for so you may get multiple payments, excuse me, you'll get one payment with the different reports being put onto the PQRI Feedback Report that you'll get later on.

It says that TIN will get a remittance advice. Basically what the remittance advice for us was that we got a tax for X number of dollars.

And then going onto getting the Feedback Report is how we're going to talk about as we go along here also.

The reports were available as of July, 2008. We did not get an interim report or we're not planning on getting an interim report for 2008 and 2009.

The mechanism for doing this is what we're going to talk about this IACS-PC, the Individuals Authorized to Access CMS Services Provider Community.

In order to do that there is a step-by-step process through registration, requesting authorization to see your PQRI Report and then actually entering the PQRI Report.

Slide 49 is (firstly) is applying to register. On this there's two basic mechanisms for registering. There's individuals and organizations.

There's individuals are those who do not reassign their benefits to another party such as employer, partnership or group and will access their PQRI Reports personally. That became somewhat confusing for a lot of people who have their own corporation but they are their own doctor or the only doctor in the group.

If you use an EIN other than your individual Social Security Number, you actually need to file as an organization. You cannot file it as an individual and still be able to look at the information. You need to be filing that - if you're an individual you basically have to be a sole proprietor and you have to have your own Social Security Number to be submitting as such.

The next aspect is organizations. And those are people who reassign their payment such as an employer, partnership or group or individual professionals

who want to use their staff to access their Feedback Report rather than themselves.

Next slide, with the organization you must create several roles. And this became quite confusing for myself. I had spoken to our Medicare advisor and had talked about different mechanisms for doing this. We have followed some of the recommendations but didn't actually realize all the idiosyncrasies to it.

One of the first components is that the first person that has created a security official, this person does not and that's very important, does not have access to the Feedback Reports. They simply control who can register in the IACS process.

You can create a backup security official. We'll talk about why we would do that in a few moments here.

You then must create a User Group Administrator, a UGA. And you can also create additional end users.

In my specific situation, my specific office I have four doctors plus several staff people obviously.

And what we did is I created myself to be the security official and I did that accidentally because that was what I thought I needed to do initially. Once I started to go in and trying to find out my PQRI Report, guess what, couldn't do it.

I contacted the people at IACS through the End User Support Help Desk which is the next slide, it gives the information there.

And they explained to me, no thank you very much, you can't do this. You need to go in and create a User Group Administrator.

Luckily one of the associates in my group is my wife who is also a physician and she was created to be the User Group Administrator.

The purpose of the security official again goes back to the aspect that when she decided that she was going to become the UGA and she wanted to review the report, every time that she filled out the IACS application which we will again go through along the process here, everything that she applied to had to go back to be being a security official who authorized that yes, I know this person. Yes, I authorize her to do these things. Yes, I authorize her to review the reports.

As a security official you cannot share this information.

So it was quite interesting to have the End User Support people communicating with myself and my wife and I have to leave the room. They were - it was very nice in the aspect they gave us lots of information but they ended up making it that we could not be sharing the information on the computer at the same time.

They - you know obviously security is a key issue. Sharing of information is a key issue and I thought that it was quite appropriate for the mechanism for them to do it.

They talk about in the organizational setup that you could consider having a staff person do it, your security official in your office, and then you have the ability to be a UGA. That is an individual decision that each practitioner would need to create and be fixed and figure out.

There is some background checks associated with the security official. The End User Support Desk does make phone calls and inquiries to the organization to make sure that the person is an employee and does have authority within the organization to be such a security, you know, a level of security.

Slide 51, what happens is after you do your original - your initial application where you're filling in the information, you then will get an email from IACS saying that they got your request and they assigned you a request number.

It states here that, you know, within 24 hours if you don't get notification that you should contact them. I will tell you that it was definitely within 24 hours that we started getting the phone calls from the End User Support Desk which gave us the inquiry, you know, whether or not the security officer was applicable.

And it was pretty funny having my staff say that yes, I work in the office and yes, I know who - they knew who I am and they've known me for a long enough time that I was available to do it.

It states also that we should allow ten days for registration process. I basically gathered that there really is not a major influx of doctors that have registered for this because my process, my registration process got finished in less than about a half an hour. Things got done quite quickly, quite efficiently, emails back and forth, telephone calls and very easy in that mechanism.

Now when you get to Slide 52 it talks about the initial IACS login.

What you're going to do is you're going to create in your - I'm actually looking for the document at this point, when you create, you're going to create a profile. You're going to get a user ID number which is sent to you via the initial registration.

You put in your name, birth date and email contact information. And that's basically how you go to get the initial component of it.

It will then send you an email with a password. You then have to go back into the web site, go to Account Management and then My Profile and you can change your password to any one that you prefer.

The - again this is kind of going fairly quickly in this slide, going to Slide 53, again talking about accessing the PQRI Report portal, accessing the portal for reporting.

I will state that there probably and if I look at my documents here, those probably from myself to become the security officer it took all of about three to four emails plus one to two phone calls from the EUS. Again this all - once it started happening rolled along quite quickly.

When my wife, Dr. (Mary) Richman decided to get to become the UGA there was now a slew of emails. She's on her computer doing hers, doing the application, filling out the same questions and conversations that we talked about here plus also the information - every time she would apply for any types of change to our status it would have to be approved me as a security officer.

So if you have larger groups and you have a security officer, what that security officer does is have the ability to authorize whether or not a person

can be a User Group Administrator, whether the person can be an end user, whether the person has access to any or all of the documents that CMS is currently utilizing.

I'm going to step again regarding - step back a tiny bit regarding how that application goes and this goes back to part one and two there.

And that is part you do is you have to go into the CMS application portal. From there you're going to select Account Management, then you go to the New User Registration.

And again this is all on the CMS web site. There are several different links that are involved in there.

But I think it's important for us that there is a step-by-step component. Within that aspect you then go to the Provider Supplier Community. That's where you can register either a security officer or an end user or a User Group Administrator.

That's how they then will start to send you these emails and verification mechanisms.

So there is a step-by-step component. CMS does have several different links on their web site on how to do this. I think it's very important to take a look at those if you're actually considering doing this.

Back to Slide 53. Once you now have completed your IACS application, you now must go to a completely different web site which is called Qualitynet.org.

That is the PQRI portal. Within there you can actually start to get to see the information. You would then need to enter your user ID, your IACS user ID number and your password. It uses the same one luckily that you just created for your IACS.

You then are able to access the information, excuse me. The UGA or an end user may. The security officer, I still cannot go in and access the information at this point.

You know if an end user chooses to share his or her information with me after the fact they are allowed to do that but that is their decision. I am not able to do it.

On Slide 54 are the two links, excuse me, the several links that we were talking about as far as how to go about doing each of these steps, the step-by-step process, first of registering, getting authorization and then getting into the PQRI portal. I definitely think that 54, 554 of you have access to that or the slide, take those links because those are the ones that are going to give you the specific information that we're talking about today.

Now we're going to talk about the actual Feedback Reports themselves on Slide 55.

And let's take a look at this.

On Slide 55 we're going to actually skip over that.

And we're going right to Slide 56 so that we have the ability to look at what some of these reports look like.

On the first page there's Table 1. And on Table 1 what it's going to do is it talks about the earned incentive summary for the Tax ID Number.

It has all the featured participants listed by NPI and a breakdown of each of the individual's earned incentive.

Again this information is accessible only by the Tax ID Number or by the, you know, by the group number that's in there and the information that's going to be shared.

In our situation it was interesting, even though my UGA was my wife, Dr. (Mary) Richman, her report did not even have her NPI name on it. It had one of the other associate's names when it list on there.

Again it breaks it down basically whether or not they made their incentive and that's, you know, if we talk about it, we're looking at the slide on the left hand side that has NPI listed down there. It has the NPI name.

And you see on this one it has not available. Well all of ours had not available except for one. I'm not sure, maybe later Dr. Green maybe able to share with us why they were not available.

It talks about whether or not the incentives were received and the rationale for it. It explains also the measures that were eligible for each of the NPI numbers, the measures that were reported and then the actual dollar amount that was generated based on each of the providers.

On the next slide what ends up happening they're talking about the NPI reporting in detail.

And that's going to be, it was - they submitted at least one valid PQRI measure.

And when they have this there's actually each one of the providers, and again I stated before that I had four - there's four physicians in my office so each person was able to get a report out of the UGA, out of the User Group Administrator, was able to see everybody's reports and what their measures were, what level they were able to do and how well they did.

When I specifically looked at mine, I actually reported on six different measures of which it was stated that there were 11 measures eligible for me to report on. Of the six that I reported, and again we're taking a look in the slide that's up here again 557, in the yellow part kind of in the middle there it says measures eligible. There's an arrow pointing to it. In this one it says two and they've got two out of two.

In mine I reported on six. I reported over 80% on six and it gives me then the dollar amount in the end there.

Below it it actually had each of the different measures that are - that were reported.

It states, you know, and again on mine I used all six of the eye measures at that point the cataracts, age-related macular degeneration, diabetic nephrothopy, primary open angle glaucoma, just all the different components that were in there and I ran 100% across the board on all of them except for one where apparently somebody missed something when, you know, I didn't circle something when I was doing it.

With that it has the whole component out there and it has the actual opportunities to report on there as well as the number of reported instances and it gives you a ratio at the end of it.

Now the next slide is talking again about performance in detail. And it talks about if something else was done and it gives specific - into the statistics as far as whether, you know, how many times you reported it, whether or not you used exclusion measures on it, the clinical performance number, the denominator versus numerator was listed in there and it talks again about the overall performance rate.

What was interesting and goes over here is that Dr. Wartman had referenced both in Slide 12 and in Slide 35 that there were measures outside of the standard reporting that was as AOA had discussed with our membership.

Those are the ones again I believe it was Slide 35, yeah, Slide 35, where even though I reported on six it said I was eligible for reporting on 11. The ones that were not reported by myself were the ones that were on Slide 35 specifically screened for future forward, the advanced care plan, assessments of urinary incontinence, screening for osteoporosis and medication reconciliation.

These were all things that were reported on my measure - my evaluation that I did not report on that I apparently could have reported on.

All right now Slide 59, again I'm going to state. It says where to go, you know, it asks where to go for help with your Feedback Reports. I will state that the externally User Services Help Desk was outstanding. Every single time that I had any question, how small or how big, somebody there was able to help me, walk me through it with either filling out the application or

stepping through or getting this information that I'm giving to you at this point. I contacted them numerous times over the several days to get it so that it would - that everything would fall into place appropriately.

Then also the quality help - Quality Net Help Desk, I had to contact them once, also it was quite easy.

The references that we had originally that I talked about several slides back on Slide 54, those references most everything is in there that you will need but , you know, I know and again here I like to talk and those issues are - it's nice to have a person to actually talk to.

Summary, do you - Dr. Wartman do you want me to go over this because that's pretty much your stuff at this end?

Rebecca Wartman: It's up to you. I'll be happy to.

Harvey Richman: Please.

Rebecca Wartman: Okay. Just as a reminder the 2008 PQRI reporting period was January 1, 2008 to December 31st for submission of the Quality Data Codes through claim submission.

And July 1, 2008 to December 31st was when the new alternative reporting mechanism took place however again those are registry use and the like probably don't apply to eye care very much.

Eleven measures are available for use by ODs in 2008. Four of the seven two thousand and - four of the 2007 measures were carried over with minor changes.

There were seven new measures available for use by optometrists in 2008.

Success requires at least three measures filed 80% of the time.

Number six, some use of the G-Codes instead of CPT II codes and modifiers was required.

The AOA web site listed and still lists all the up-to-date information on PQRI.

In 2008 the bonus will be 1.5% of all allowable Medicare charges.

Slide 61, 2007 PQRI bonus payments and Feedback Reports are available as of July, 2008; Congress has expanded the program for 2009 and increased the bonus payment to 2% so it becomes more financial - a bigger financial incentive.

We may have three new eye measures for 2009. And two of those will likely be reported by optometrists.

E-prescribing measures will be removed from PQRI in 2009 because of a statute requiring an additional payment bonus for the use of e-prescribing and again those rules are going to change over the next few years and there is a big CMS sponsored conference coming up on e-prescribing.

And you must have the proper documentation for the measure. Know the specifics. You must document plus or minus macular thickening and plus or minus hemorrhages for the age-related macular degeneration, fungus dilated fungus exam for example.

And all this information is available on the AOA web site and the CMS PQRI site and both of those web sites are listed on the - on Slide 62 of this presentation.

And I guess the eye care measures were one of the most highly reported measures that Dr. Green already said today for 2007. It may account for the fact that we did have several measures. And they were relatively in my mind easy to apply.

And the AOA does encourage all optometrists to participate in the PQRI Program and hopes to continue offering the tools and the resources to assist in successful participation.

I'll turn it back over to you Dr. Green or Dr. - or Ms. Highsmith.

Daniel Green: Well hi its Dan again. I just want to thank doctors Kehoe, Wartman and Richman for a great job at presenting a nice overview of the PQRI and the Feedback Reports.

The Feedback Reports are a difficult topic to present because they can be a little bit confusing for folks so I think great job to all of our presenters today and thank you for doing - agreeing to do this call with us.

I think as it's a little after five after the hour we will open it up to questions from the audience if there are any.

Natalie Highsmith: (Mindy) if you can just remind everyone on how to get into the queue to ask a question.

And everyone please remember when it is your turn to restate your name, the state you are calling from and what provider or organization you are representing today.

Operator: At this time if you would like to ask a question press star 1 on your telephone keypad.

Your first question comes from (Susan Galantine). Your line is open.

(Susan Galantine): Hello?

Natalie Highsmith: Hello.

(Susan Galantine): Hello. This is (Susan Galantine). I'm calling from Southwest Retina in El Paso, Texas.

I actually have a couple questions here. I had been on the call a couple days ago as well and we didn't get our question answered.

The first question is we got a remittance from Medicare with the N365 remarks for reporting purposes only.

But when we go onto IACS we have no report available. And when we call Medicare or TrailBlazer, our carrier they have no idea what we're talking about.

Do we have any idea of what went wrong or so we can resolve this?

Daniel Green: TrailBlazer should be able to actually answer some questions for you at that point.

If you want to give me some contact information, I'll forward your name to someone who's looking into it, might be able to give you some better answers.

(Susan Galantine): Okay.

Daniel Green: I'll have to confess I'm not the expert with the Feedback Reports and problems that folks have had with that.

So but I'm happy to take your information and forward it onto somebody to get in touch with you, might be able to provide you more information.

(Susan Galantine): Okay, sure, sure. Again my name is (Susan). I'm with Southwest Retina. The phone number here is 915-532-3912.

Daniel Green: Okay, someone - it may take a couple days but someone will be in touch with you.

(Susan Galantine): Sure, that's fine. But you know what I have two more questions real quick.

Daniel Green: Okay.

(Susan Galantine): Okay. We are reporting as a practice. We have three doctors in our practice and it got a little bit confusing when we added a fourth doctor.

If we're reporting as a group, right, so the overall group reports. If doctor one let's say submits a measure in January, can doctor two submit another measure in May...

Harvey Richman: Yeah.

(Susan Galantine):...because it's going individually, right, and then by the group?

Harvey Richman: Right, it's - I mean you can certainly report. Basically the reporting is done at the NPI Tax ID level so each provider would be treated and do it individually here at CMS.

(Susan Galantine):Okay.

Harvey Richman: So you can have one provider that's participating and the other three aren't or you could have, you know, any combination up to and including all four providers.

(Susan Galantine):Okay.

Harvey Richman: So basically, you know, provider one would want to submit on 80% of his or her eligible patients for whatever measure they're reporting and obviously the three measures would be required.

(Susan Galantine):Right.

Harvey Richman: So they could report on the same patient. Let's say Mrs. (Jones) comes to see provider one in January and then in May she comes back when she follows up with doctor (Smith).

Both providers could actually report for the same patient and it might be the same, you know, Quality Data Codes. You know again as long as they fall into the eligible population for that particular measure for that provider.

(Susan Galantine):Oh, okay.

Harvey Richman: But for them to both get credit they would both need to report.

(Susan Galantine): Okay. Okay, and then I was also looking here on Slide 18, so it says we have to document the presence or, you know, non-presence of macular thickening and hemorrhages.

Do we just document that in our records or do we have to document that on our actual claim?

Harvey Richman: Rebecca.

Rebecca Wartman: If you don't mind I'll take that question.

Harvey Richman: My pleasure.

Rebecca Wartman: You have to document it in your record.

(Susan Galantine): Okay, just the record.

Rebecca Wartman: And while you would not be audited strictly for quality measures, if you were audited during a time period of quality measures my understanding is that documentation would need to be present.

(Susan Galantine): Okay. Yeah, I was just making sure. I was like uh-oh maybe that's why we didn't get any.

Rebecca Wartman: No.

(Susan Galantine): Okay. Okay, well that was all for me then.

Operator: Your next question comes from (Dawn Andrica). Your line is open.

(Dawn Andrica): Hi, my name is (Dawn). I'm calling from Armstrong Eye Care Associates in Pennsylvania.

I did not get the slide web site.

Natalie Highsmith: It is on...

Rodney Peele: This is Rodney. I can answer that.

Natalie Highsmith: Go ahead please, yes please.

Rodney Peele: It's on the American Optometric Association web site on the front page. That's www.aoa.org.

(Dawn Andrica): Okay.

Rodney Peele: And it's listed on the right hand side of the page.

(Dawn Andrica): Right hand side, okay.

Rodney Peele: September 24 PQRI Forum Presentation.

(Dawn Andrica): Okay, thank you.

Operator: Your next question comes from (Kelly Magoti). Your line is open.

(Kelly Magoti): Hi, my name is (Kelly). I'm calling from Dr. (Scott Goldberg)'s office in Pennsylvania.

And I have a couple questions. When you say we're supposed to report three measures 80% of the time, does that mean three measures per patient we're supposed to be hitting? I'm just confused on that.

Rebecca Wartman: All right, if you don't mind, this is Rebecca, I'll be glad to answer that question.

It's three measures 80% of the encountered time where it's applicable.

So it doesn't have to be three measures on each patient because obviously each patient may not have the disease.

But if you're seeing patients with macular degeneration, for instance filing a 92004 and the diagnosis code of 362.50, any patient you have with those two - with that diagnoses and procedure code who is over 50 years old and you've documented macular thickening and/or pain, yes or no, then you have to report that at least once in a 12 month period to meet the measure.

(Kelly Magoti): Oh, okay.

Rebecca Wartman: So you don't necessarily have to report it each time you see the patient.

However due to just bookkeeping and all that kind of stuff trying to keep track of it, it doesn't hurt and you're not penalized for reporting that measure every time you have the right code and diagnosing situation to meet that measure. It may be more than is really necessary but there's no penalty for doing that.

And that way you don't miss the 80%.

(Kelly Magoti): Okay, great. And another question if you don't mind, for the 2027F code, does that require that they be dilated every time we report that without a modifier?

Rebecca Wartman: This is Rebecca. 2027 does not require dilation.

(Kelly Magoti): Okay.

Rebecca Wartman: It only requires an optic nerve evaluation.

(Kelly Magoti): Oh okay, great. And final question, there's the new tobacco measures.

We pretty much ask people every time they come, you know, do you smoke that type of thing, so is that something we can report every time as long as we do that?

Rebecca Wartman: Well as long as you meet the measure guidelines. I did not get into the specifics of reporting.

And the tobacco measures are fairly extensive in terms of whether they use smoke tobacco, smokeless tobacco and exactly what you do to advise them to quit.

(Kelly Magoti): Okay.

Rebecca Wartman: But yes, you can report those as long as you're meeting the specific guidelines of the code. Those are really detailed on the AOA web site in a different set of information on PQRI. I did not go into details on those.

So you are eligible to report those, yes.

(Kelly Magoti): Okay, all right. Well thank you very much. I appreciate it.

Operator: Your next question comes from (Joann Riedleberger). Your line is open.

(Joann Riedleberger): Hi. I have - my name is (Joann Riedleberger). I'm calling from Rosenthal Optometric.

My doctor had two questions. On measures 12 and 14 when it says that you have to report it at least once in the past 12 months.

She wants to know is that done each time when she's dilating the patient or just one time and then she can go on from there.

Harvey Richman: I think that - this is Harvey Richman again. I think Dr. Wartman if I'm correct has stated that for bookkeeping purposes it's easier to just report it each time that you've done it.

(Joann Riedleberger): Okay.

Harvey Richman: All right. I mean you can go ahead and do it each time. If you don't dilate the patient make sure you use the appropriate modifier why you're not using - why you're not dilating the patient.

(Joann Riedleberger): Okay. All right, okay.

Rebecca Wartman: Yeah for that specific measure dilation isn't required.

However it is - the denominator does say at least once in a 12 month period.

(Joann Riedleberger): Okay. So its just best to cover ourselves to just report it each time to make sure that we've got it all covered with our reports and everything else.

Rebecca Wartman: That's been the advice of the AOA.

Dr. Green do you have any suggestions on that?

Daniel Green: Well there is no penalty for over-reporting so that's fine.

Again as long as its done on the patient and reported at least once during the 12 month reporting period.

(Joann Riedleberger): Okay.

Daniel Green: The reporting period, you know, January 1st through December 31st.

So if the patient is seen sometime during that 12 months, you know, we would need to see that code come in for that patient at least once.

But as Rebecca and Harvey both said there is no penalty for over-reporting and it might just be easier for you all to just report each time.

But again either way you want to do it.

(Joann Riedleberger): Okay. Okay and one other question she has.

With the diabetes measure, if they - the 2021F and the other ones are applicable for one patient can she report all three of them or not?

Rebecca Wartman: Yes, you can. In fact you may actually have four codes to report on a diabetic patient. If they're between 18 and 75 and they have retinopathy you would report 2021F.

(Joann Riedleberger): Okay.

Rebecca Wartman: You would report 5010F and G8397 if indeed you met the goals for 2021F.

(Joann Riedleberger): Okay.

Rebecca Wartman: And you may report 2022F saying that you dilated that diabetic patient.

(Joann Riedleberger): Okay.

Rebecca Wartman: So it's possible that you could have four different lines that you would have to put in.

(Joann Riedleberger): Okay.

Rebecca Wartman: Now if you did not dilate that patient and they were the right age, 2021F with the appropriate modifier, excuse me, 2022F with the appropriate modifier and G8398.

(Joann Riedleberger): Okay.

Rebecca Wartman: Without retinopathy. With retinopathy, oh it gets more confusing. You really have to sit down and study each code.

One of the things that the AOA did put out and is available on the web site is a two page kind of coding summary that gives fairly good detail on what you need to do for each measure.

And I find that very helpful just chairside when I'm doing my coding.

((Crosstalk))

(Joann Riedleberger): Okay, great. I will look into that. Thank you very much.

Operator: Your next question comes from (Sandra) Regenye. Your line is open.

(Sandra) Regenye: Yes, this is (Sandra) Regenye with Horizon Eye Care.

And I'm asking a question in reference to the Feedback Reports. I've heard more issues about undercounting of our reported instances.

However we have a situation where CMS's Feedback Report is indicating that we (81) more cataract surgeries than we did.

And I've tried to follow-up and find out how I can determine where they came up with that number and I've had no success.

Any suggestions?

Daniel Green: Well that's unusual and congratulations. You've stumped the question answerer.

Why don't you give me your email and again I will forward it onto someone who hopefully will get in touch with you and you can explain the situation. They might be able to help you.

(Sandra) Regenye: That would be great. My email is sregenye@horizoneyecare.com. That's H-o-r-i-z-o-n Eyecare.com.

Daniel Green: Eyecare.com. Okay. And I'm sorry, your name again please?

(Sandra) Regenye: (Sandra) Regenye.

Daniel Green: Thanks so much.

(Sandra) Regenye: Thank you.

Operator: If you would like to ask a question press star 1 on your telephone keypad.

Daniel Green: I'll take it that there are no more questions in queue.

Operator: Not at this time.

Daniel Green: All right. Well why don't we give folks another 30 seconds or so and if not we'll wrap up.

Operator: We do have one question from (Mary Ellen). Your line is open.

(Mary Ellen): Yes. I'm calling from Innovative Eye Care in Decatur, Alabama.

And I did have a question. I got in a little late on the presentation.

But did I understand that this can be filed electronically as well as paper forms. I know most of us are filing electronically now.

So that is still something that would be acceptable. Is that correct?

Rebecca Wartman: This is Rebecca Wartman. Certainly in fact everyone encourages you to use electronic filing so there's no problem in that.

(Mary Ellen): Okay. We have a new software system in our office and it's set up with CPT codes and everything.

So would this require because of all the different measures and everything, would this require that we go in and set up separate coding in order to be able to take part in this?

Rebecca Wartman: If you do not have the CPT II codes, the Quality Data Codes or the G-Codes that are required then those need to be added.

But if it's a commercial system I would imagine those are already in there.

But you need to double check that they're all there.

(Mary Ellen): We're using Medformix. It's by Crowell and...

Rebecca Wartman: I'm not familiar with the...

(Mary Ellen): Okay.

Rebecca Wartman: ..specific programs.

But at any rate I would check and see if those CPT II codes and the G-Codes are in there and in there properly so that you can then add them to your claim.

(Mary Ellen): Okay.

Rebecca Wartman: But you would enter them just like you would any procedure code or an E&M code.

(Mary Ellen): Okay, so it would just have like an alternative set of codes, the CPT II codes that would be used for Medicare patients only as opposed to (Sibley), (Cross) or someone else.

Rebecca Wartman: Right, for instance.

(Mary Ellen): We'd use the regular CPT.

Rebecca Wartman: For instance you might file a 92004 with a diagnosis code of macular degeneration which maybe be 362.51.

And then you would file the 2019F matched to the diagnosis code of macular degeneration.

And the C would be either zero or if it requires some nominal make it a penny or something.

(Mary Ellen): Oh okay.

Rebecca Wartman: It's pretty small.

(Mary Ellen): Okay, all right.

Rebecca Wartman: So it's just a separate line on your regular claim.

(Mary Ellen): Okay, thanks.

Rebecca Wartman: That link - it's got to be linked to the diagnosis.

(Mary Ellen): Right, okay. Thank you very much.

Harvey Richman: Before you go there's one other component to that also which and that goes back to the updating of the software. We use a little bit larger, more commercially ready software program for practice management. It does include the CPT II codes as they're updated.

But due to the fact that CMS came out with the updates in July, or excuse me, the second half reporting measures, that stuff was not incorporated into our software management companies.

So you do have to go in there. I also think that you had made a statement regarding you want to link these only to the Medicare claims and that is correct that Medicare is the only one that is using these measures at this point.

But I believe that most of the practice management systems that are out there have it as an option that you can do it on any of them. And I would think that that would be something you would want to make sure you have in case other third parties entities do start to use these at sometime in the future.

(Mary Ellen): Okay.

Harvey Richman: So I wouldn't just link it strictly only to the Medicare when you go in and program the software for yourself.

(Mary Ellen): So it sounds like there is potential that this will be something that's started by the other insurance companies as well, correct?

Harvey Richman: I didn't - I said it's a possibility. I have no knowledge of such.

(Mary Ellen): Okay. Okay, but just in case it wouldn't hurt.

Daniel Green: There are some plans out there actually that are starting to look at pay for actual - pay for - I'm sorry performance instead of pay for reporting and they have different ways that they go about this.

The CPT II codes are owned if you will by the AMA so those are not necessarily specific to CMS or Medicare or patients. Those would be applicable to any patients for whom the measure qualified.

Now the G-Codes are - have been developed by CMS and they're designed to be temporary although some of them have been in existence for more than a year. There - until the AMA has an opportunity to come up with CPT II codes for those quality actions.

(Mary Ellen): Thank you.

Operator: Your next question comes from (Dan Hemick). Your line is open.

(Dan Hemick): You said the materials will be available from CMS on November 15th.

What method do we access that by or when would AOA have a nice little summary sheet updated for us?

Harvey Richman: I'm waiting Rebecca.

Rebecca Wartman: Typically as soon as the measures come out what has been done in the past years. Those are posted on the CMS web site, on the PQRI site, correct Dr. Green?

Daniel Green: They will ultimately be posted on our web site.

But the - I think the November 15th date that was thrown around, we're actually - we're hoping to get it out by November 1st but it may be up until November 15th for the final rule which will be posted in the Federal Register.

So it can be viewed most quickly there and there is a web site where sometimes it's also posted even if it doesn't come out in print till sometime mid to end of November. It's actually available electronically on the web before that.

And that's where we'll announce which measures are going forward for 2009.

Rebecca Wartman: Yeah, and if I'm not mistaken sometimes while the measures are in place the specifications of the measures are subject to change until the end of December although terribly likely.

Daniel Green: Well that's absolutely correct. We do our best to try to get these measure specifications out beginning - I'm sorry, middle to the end of November.

But the secretary does have the right to change any specifications up until December 31st.

Again we realize the burden that that places and the hardship is endured by practices so we do our best to not have that happen at the 11th and half hour but sometimes it's necessary if something is discovered to be a major, you know, problem with reporting a measure.

Rebecca Wartman: Correct. At that point they - typically in the past two years I've been the one to kind of filter this down and make it a little bit more digestible for the AOA members.

And as soon as I get it I try to turn that around within the week and get it back out.

So as soon as we have it we'll get it to you as soon as possible.

And Rodney correct me if I'm wrong, we'll send out all sorts of electronic messages that that's there.

Rodney Peele: That's correct. We will send messages out to the various publications that materials are available for 2009 reporting.

And the AOA will take the information from CMS and concentrate on the measures that we feel be applicable for optometrists to use.

Rebecca Wartman: And just to further the question or answer to the question, in the past we've tried to sponsor at least one webinar and then put that in recording on the AOA web site as well.

So we try to give it to you in print on the web site as well as something that you can actually listen to.

(Dan Hemick): All right, thank you.

Operator: Your next question comes from (Cathy Wilcox). Your line is open.

(Cathy Wilcox): Hi. My name is (Cathy). I'm calling from (Nobi) Eye Care Center in Illinois.

And there's been assumption on my part that because the information is being processed through CMS that - the word is escaping me - alternative Medicare payors such as (Advantage) that we do not want to submit the information through them or it doesn't get processed if it goes through them.

Daniel Green: I'm assuming that you're talking about Medicare Advantage patients perhaps.

(Cathy Wilcox): I believe that's correct.

Daniel Green:: Okay, so like a patient that has Medicare kind of through United or...

(Cathy Wilcox): Yes.

Daniel Green: ...or one of the other insurance companies.

So those - Medicare Advantage patients would qualify as Part C Medicare patients.

So Medicare - I'm sorry PQRI is a Medicare Part B Program.

So bonuses are calculated based on Medicare, covered Medicare Part B charges and we're looking for Quality Data Codes to be submitted only on the Medicare Part B patients.

(Cathy Wilcox): Okay.

Daniel Green: So again this is on Part B and looking for quality information on Part B beneficiaries only.

(Cathy Wilcox): Okay then that is not what I was talking about. I'm sorry. They are qualified Medicare Part B but they - their insurance cards say submit here instead of Medicare.

So there's (Advantage), there's one that goes through Health Alliance. They pay us according to Medicare Part B guidelines.

Daniel Green: Right, unless they're your carrier which it doesn't sound like. It sounds more like they are in fact Medicare Advantage patients.

(Cathy Wilcox): Okay. Okay. Thank you very much.

Daniel Green: Thank you.

Rebecca Wartman: Dr. Green one point of clarification. Railroad Medicare, do they take PQRI measures.

Daniel Green: You know Rebecca that's a great question. I honestly don't know the answer to that. That's the first time in a year and a half I've been asked.

Rebecca Wartman: My understanding was yes and I know the claims have not been kicked out because I put PQRI measures on them personally.

Daniel Green: Right.

Rebecca Wartman: But I don't know that for sure.

Daniel Green: Yes. I've never heard anything to the contrary. But that is something that we can try to find out for you as well.

We are coming up on just after 3:30 Eastern Time so that would conclude time allotted for today's call.

There were a lot of great questions that were asked and we do appreciate the wonderful presentations that were given by all of our doctors today.

CMS again would like to thank everyone for their participation in today's call and particularly in your interest and participation especially by the optometrists in the PQRI Program.

We hope that the program particularly as it matures will be an asset to your practice and help to improve the care that your patients receive and I'm sure you're providing it anyway so it'd be great to be able to report it to CMS and actually earning incentive payment.

So again I'm going to turn it back over to our presenters if there's anything they want to say before we conclude.

But I again want to thank everyone for their time and especially to our presenters today. Thank you.

Rebecca Wartman: My only comment is I appreciate the opportunity through CMS to do this and thank you so much for coordinating it.

Daniel Green: Our pleasure.

Harvey Richman: I agree. And I always enjoy talking with Rebecca.

Daniel Green: She's got a great accent doesn't she?

Harvey Richman: You've got it. She doesn't believe it but she does.

Daniel Green: And I think it's a Boston accent but I'm not sure.

I'm going to turn it back to Natalie real quick to conclude the call.

So thank you all again and here's Ms. Highsmith.

Natalie Highsmith: Thank you everyone for joining us.

(Mindy) can you tell us how many people joined us on the phone?

Operator: One hundred and eighty.

Natalie Highsmith: 180?

Operator: Yes.

Natalie Highsmith: Wonderful, thank you all again.

Operator: This concludes today's conference call.

You may now disconnect.

END